CENTRAL REGISTRY CLEARANCE REQUEST
Michigan Department of Human Services

INSTRUCTIONS:

- An enlarged and clear copy of individual's photo identification must be attached.
- For Michigan employers, individuals and volunteer agencies, submit this request to the local County Department of Human Services. To obtain the address and fax number of **your local county DHS, access www.michigan.gov/dhs->Inside DHS.**
- For individuals seeking clearance on themselves, the results will be sent to the address on the picture identification provided.
- Outstate Children's Protective Services workers, law-enforcement, and court officials fax request to 517-241-7047 (Outstate only) on agency letterhead with cover sheet.
- All fields must be completed for processing.

COPY PHOTO ID HERE AND RETAIN A COPY FOR YOUR RECORDS

OR ATTACH A CLEAR COPY OF YOUR ID ON A SEPARATE PAGE

SECTION 1
INFORMATION ON PERSON BEING CLEARED

Name First, Middle, Last	AKA (Also Known As) (Maiden Name)	Social Security Number	Signature Required for individual being cleared
Address	**Phone Number**	**Date Of Birth**	

SECTION 2
REQUESTOR INFORMATION

Please Check Appropriate Box

- ☐ Child Welfare Agency
- ☐ Individual ☐ I would like to pick up my results in _____ county
- ☐ Law-Enforcement/Dept of Corrections
- ☐ Prosecuting Attorney/Court (please provide docket number if available) _____ MI
- ☐ Employer
- ☐ Volunteer Agency
- ☐ Out-of-State Adoption and Foster Home Screening
- ☐ Other _____

Name of Employer/Volunteer Agency/Individual		Name of CPS/Law-Enforcement or Court	
Name		Title	
Address	City	State	Zip Code
Phone - -	Fax - -	E-mail	Date

Employers/volunteer agencies – will ONLY receive responses of NO central registry if the name being cleared has approved this request with their signature. Employers/volunteer agencies will NOT receive notification if the name submitted has any central registry history hits per CPL 722.627.

For questions about completing this form, please contact the local Michigan Department of Human Services, Children's Protective Services or CPS Program office at 517-373-6028. Mail questions to PO Box 30037, 235 S. Grand Avenue, Suite 510, Lansing, Michigan 48909

This clearance does not identify individuals who may have child abuse/neglect history in other states, territories or tribal trust land.

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

If you have multiple individuals in the home that will require additional forms, please print additional copies of this form before filling it out.

MEDICAL CLEARANCE REQUEST

Michigan Department of Human Services
Bureau of Children and Adult Licensing

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE MAIL TO ➡

Licensing Consultant (Name, Address, Phone)
Department of Human Services
Bureau of Children and Adult Licensing
7109 W. Saginaw, 2nd Floor
P.O. Box 30650
Lansing, MI 48909-8150

License Application Type

- ☐ Adult Foster Care (24-Hour Care)
- ☐ Child Foster Care (24-Hour Care)
- ☒ Child Care (Less Than 24-Hour Care)
- ☐ Capacity _____

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Telephone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the care facility listed above and to the Michigan Department of Human Services, Bureau of Children and Adult Licensing, for the purpose of determining my suitability to provide or be associated with the care of children/dependent adults.

Date

Patient's Signature

Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- **This individual is, or will be, employed in a child/dependent adult care setting.**
- **It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child/dependent adult and the quality and manner of his/her care.**
- **To assist us in this determination, you are being asked to answer the following.**

Has this Person Been Tested for T.B.?	Date Tested	Test Type	Results
☐ No ☐ Yes If Yes ➡		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

- ☐ No physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults.
- ☐ Physical/mental condition or health problem exists that would not limit the ability to work with or around children/dependent adults. Explain in Comments if reasonable accommodation may be needed.
- ☐ Physical/mental condition or health problem exists which would affect the ability to work with or around children/dependent adults, with or without reasonable accommodation.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Physician's Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: 1973 PA 116
1979 PA 218
RESPONSE: Voluntary
PENALTY: Application for licensure may be denied.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

bloomin' preschools

EMPLOYEE/VOLUNTEER STATEMENT

ABUSE NEGLECT AGREEMENT

I _____

Name

(a) am aware that abuse and neglect of children is against the law.

(b) have been informed of Bloomin' Preschools/Latchkey/Kidz Zone policies on child abuse and neglect.

(c) know that caregivers are mandated by law to report abuse and neglect immediately.

(d) have never been convicted of a crime other than minor traffic violations.

(e) do not have any convictions and/or history of substantiated abuse or neglect of children or adults.

(f) do not have any convictions of a felony involving harm or threatening harm.

(g) as a volunteer I will be directly supervised by staff at all times.

_____ _____

SIGNATURE DATE

_____ _____

PROGRAM LOCATION

I ACKNOWLEDGE THAT I HAVE RECEIVED THE SAFETY TRAINING FROM BLOOMFIELD HILLS SCHOOLS AS OUTLINED BELOW.

BLOODBORNE PATHOGENS- You Must Complete HEP B Form

DATE OF TRAINING:
NAME OF EMPLOYEE:
SIGNATURE OF EMPLOYEE:

SECLUSION AND RESTRAINT – Online Video Training Viewed

DATE OF TRAINING:
NAME OF EMPLOYEE:
SIGNATURE OF EMPLOYEE:

EPI-PEN Video Training Viewed

DATE OF TRAINING:
NAME OF EMPLOYEE:
SIGNATURE OF EMPLOYEE:

AED- Online Video Training Viewed

DATE OF TRAINING:
NAME OF EMPLOYEE:
SIGNATURE OF EMPLOYEE:

HAZARDOUS COMMUNICATION/MATERIAL SAFETY DATA SHEETS

DATE OF TRAINING:
NAME OF EMPLOYEE:
SIGNATURE OF EMPLOYEE: